Alabama Medicaid Provider Enrollment

Out of State Pharmacy Enrollment Application (Basic Materials)

Alabama Medicaid Basic Provider Enrollment Information Form
Program Participation Signature Form
Alabama Medicaid Provider Participation Requirements

- The completion of this application is only applicable for out-of-state non-bordering pharmacy providers (i.e., providers who are located more than 30 miles from the Alabama State line) who are requesting to be enrolled on a temporary basis for emergency situations and/or date of service only.
- The date of service must be indicated on the Program Participation Signature Form supplied in the application.
- Providers must meet the minimum requirements outlined in the Alabama Medicaid Provider Participation Requirements of this application.
- Please type or print legibly using **BLACK or BLUE INK ONLY**.

GENERAL INFORMATION PAGE

(1) The following information should be completed on Applicant:

Name of Enrolling Pharmacy: _____

Physical Address: _____ (City) _____ (State) _____ (Zip Cd +4) _____

Mailing Address:_____ (City) _____ (State) _____ (Zip Cd +4) _____

Business Phone No: (____)_____ Fax No: (____)_____ Toll Free No: (____) _____

Name of Supervising Pharmacist: _____

Indicate Type of Pharmacy: _____ (Government Owned, Institutional or Retail)

Indicate the Medicaid Number (for the state in which the pharmacy is located): _____

(2) Has the license/permit for the supervising pharmacist or other persons associated to this business ever been limited, suspended or revoked in any state, or has your Medicare-Medicaid participation ever been limited, suspended or revoked? **Yes** ( ) **No** ( ) If yes, attach a full explanation.

(3) Please complete the following information. This information will be used on your tax statements. This information must be consistent with the payee information provided to the IRS. If payee is someone other than the name listed in Section 1 (such as a corporate name) please indicate that name as the tax name.

Tax Name :_____ IRS Tax No: _____

Payee Address: _____ (City)_____ (State)_____ (Zip Cd +4) _____

Business Phone No: (____)_____ Fax No: (____)_____ Toll Free No: (____) _____

Contact Person:_____ Phone Number of Contact Person:_____

(5) If you have previously obtained a provider number, under the same information above, you may choose to re-certify that number.

Please indicate provider number to be re-certified here:_____

If there are any questions concerning the completion of this application, please contact our Provider Enrollment Unit. Our Toll-Free Number is 1-888-223-3630 or 334-215-0111. Return this form to EDS, Provider Enrollment, P.O. Box 244035 Montgomery, AL 36124. Please remember to retain a copy of this document in its entirety for your records.

FOR OFFICE USE ONLY, DO NOT WRITE IN THIS AREA

Provider Number: _____	**EDS ACTION** DATE: _____ BY:_____ _____ _____ _____

SIGNATURE PAGE

Must be signed with an original signature

To the best of my knowledge, the information supplied on this document is accurate and complete and is hereby released to EDS and the Alabama Medicaid Agency for the purpose of issuing a Medicaid provider number.

I hereby authorize, consent to, and request the release to the Alabama Medicaid Agency of any and all records concerning me, including, but not limited to employment records, government records, and professional licensing records, and any other information requested by the Alabama Medicaid Agency for purposes of acting on my application to be an enrolled provider under the Alabama Medicaid program.

Signature of applicant (or an authorized representative if you are enrolling as a provider group/supplier)

_____

Signature

_____ _____

Title Date

Indicate date(s) of service: From_____ **To**_____

Providers completing this application will be enrolled on a temporary basis for emergency situations and/or for date of service only.

Do Not Write In This Area

(For Office Use Only)

_____

Date**:** _____

Initials: _____

QC Date: _____

QC Initials _____

SIGNATURE PAGE (Continued)

Penalties for Falsifying information on the Medicaid Health Care Provider / Supplier Enrollment Application

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who in any matter
within jurisdiction of any depart or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious of fraudulent statement or entry.

   Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. § 3571 Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against an individual who "knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a program under a Federal health care program.

   The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729 imposes civil liability, in part, on any person who:

   a) knowingly presents, or causes to be presented, to an officer or an employee of the United States Government a false or fraudulent claim for payment or approval;
   b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
   c) conspire to defraud the Government by getting a false or fraudulent claim allowed or paid.

4. Section 1128B(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency…

   A claim that the Secretary determines is for a medical or other item or service that the person knows or should know:

   a) was not provided as claimed; and/or
   b) the claim is false or fraudulent.

   This provision authorizes a civil monetary penalty of up to $10,000 per each item or service, an assessment of up to 3 times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. The Government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment." **Remedies include compensatory and punitive damages, restitution and recovery of the amount of the unjust profit.**

PROVIDER ENROLLMENT AGREEMENT

WHEREAS, the Alabama Medicaid Agency, as Administrator of the Medicaid Program under Title XIX of the Social Security Act and the undersigned Provider, wish to enter into an agreement concerning submission of claims for payment, without regard to media type (paper or electronic media, including, but not limited to, magnetic tape, diskette, or on-line computers);

NOW, THEREFORE, the parties hereby agree that the provider shall submit claims consistent with the provisions of Title XIX of the Social Security Act, as amended, and under the terms and conditions set forth herein.

1. Provider hereby certifies that the services described on all claims submitted under his/her provider number are true, accurate, and complete, that they were rendered by him/her or under his/her personal direction, and that the services were medically necessary.
2. Provider agrees to establish and maintain a file containing the signature of each recipient of services furnished by provider, or when applicable, the signature of a responsible person made on behalf of said recipient. Said signature shall be established and maintained for each claim submitted consistent with Alabama Medicaid Agency Administrative Code Rule 560-X-1-.18, as amended, herein incorporated by reference.
3. Provider hereby agrees to and shall be responsible for the accuracy and authenticity of claims submitted. Provider shall keep such records, including original source documents, as are necessary to disclose fully the nature and extent of services provided to recipients and to furnish this information, free of charge, to the Secretary of Health and Human Services, Alabama Medicaid Agency, and other State of Alabama Agencies upon request. Records shall be maintained in accordance with Administrative Code Rule 560-X-1-.21 and the Medicaid Billing Manual, as incorporated by reference, and shall be made available for inspection and audit on request. Medicaid shall have the right to recoup, adjust, or recover any incorrect payment made to provider.
4. Provider agrees that said billing agent listed in section (4) of the enrollment form is empowered and authorized to submit claims, regardless of media, on his/her behalf. Medicaid shall have the right to verify the existence of said authorization. Medicaid shall have the right to audit and confirm, for any purpose, information submitted by provider to said billing agent.
5. Provider agrees to accept as payment in full, the amount paid by Medicaid for claims submitted for payment in accordance with Administrative Code Rule 560-X-6-.01 (7). Provider also understands that submission of a claim, without regard to media type (paper or electronic media, including, but not limited to, magnetic tape, diskette, or online computers), is a claim for Medicaid payment and that any person who, with intent to defraud or deceive, make, causes to be made, or assists in the preparation of any false statement, misrepresentation or omission of a amount, knowing the same to be false, is subject to civil and/or criminal sanctions under the applicable state and federal statures.
6. Assurance is hereby given that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C., 2000d et seg), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C.-70b) the Age Discrimination Act of 1975 (42 U.S.C.-6101. et. seg.), the American with Disabilities Act of 1990, and the regulations issued thereunder by the Department of Health and Human Services (45 C.F.R. Parts 80, 84, and 90) no individual shall, on grounds of race, sex, color, creed, national origin, age, or handicap be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or services by this facility.
7. This agreement is effective immediately upon signing and will continue indefinitely unless amended, revised, or terminated, in writing, by either party upon thirty days written notice. This agreement terminates automatically upon disenrollment of the provider from Medicaid.

PROVIDER UNDERSTANDS THAT PAYMENT OF CLAIMS SUBMITTED WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAW.

Provider's Name	Provider's Signature
Alabama Medicaid Provider Number	Date Signed

THIS AGREEMENT DOES NOT OBLIGATE YOU TO ACCEPT MEDICAID PATIENTS

W-9

(Obtain TIN for payments other than interest, dividends, or Form 1099-B gross proceeds)

Taxpayer Identification Number Request

Please complete the following information. We are required by law to obtain information from you when making a reportable payment to you. If you do not provide us with this information, your payments may be subject to 31 percent federal income tax backup withholding. Also, if you do not provide us with this information, you may be subject to a $50 penalty imposed by the Internal Revenue Service under section 6723.

Federal law on backup withholding preempts any state or local law remedies, such as any right to a mechanic's lien. If you do not furnish a valid TIN, or if you are subject to backup withholding, the payor is required to withhold 31 percent of its payment to you. Backup withholding is not a failure to pay you. It is an advance tax payment. You should report all backup withholding as a credit for taxes paid on your federal income tax return.

Instructions:

Complete Part 1 by completing the row of boxes that corresponds to your tax status. Complete Part 2 if you are exempt from Form 1099 reporting. Complete Part 3 to sign and date the form.

Part 1 Tax Status: (complete one row of boxes)

Individuals:

Individual Name:	Individual's Social Security Number (SSN):
	__ __ __ - __ __ - __ __ __ __

A sole proprietorship may have a 'doing business as' trade name, but the legal name is the name of the business owner.

Sole Proprietor:

Business Owner's Name:	Business Owner's SSN or Employer ID Number:	Business or Trade Name
	__ __ __ __ __ __ __ __ __	

Partnership:

Name of Partnership:	Partnership's Employer ID Number:	Partnership's Name on IRS records (see IRS mailing label)
	__ __ - __ __ __ __ __ __ __	

A corporation may use an abbreviated name or its initials, but its legal name is the name on the articles of incorporation.

Corporation, exempt charity, or other entity:

Name of Corporation or Entity:	Employer Identification Number:
	__ __ - __ __ __ __ __ __ __

Part 2 Exemption:

If exempt from Form 1099 reporting, check here: ☐
and circle your qualifying exemption reason below

1. Corporation, except there is no exemption for medical and healthcare payments or payments for legal services.
2. Tax Exempt Charity under 501(a), or IRA
3. The United States or any of its agencies or instrumentalities
4. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions.
5. A foreign government or any of its political subdivisions.

Part 3 Signature:

Person completing this form: _____

Signature: _____

Date: _____

Phone: (_____) _____

ELECTRONIC FUNDS TRANSFER (EFT) INFORMATION

Electronic Funds Transfer (EFT) is the **required** payment method to deposit funds for claims approved for payment. These funds can be credited to either checking or savings accounts, directly into a provider's bank account, *provided* the bank selected accepts Automated Clearing House (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks, **ensuring funds are directly deposited into a specified account.**

The following items are specific to EFT:

- EFT funds are typically available to providers when banks open on Thursday mornings following the checkwrite (Friday in the event of a bank holiday).
- Pre-notification to your bank takes place following the application processing.
- Ten (10) days after pre-notification, future deposits are received electronically.
- The Explanation of Payment (EOP) Report furnishes the details of individual payments made to the provider's account during the weekly cycle.
- The availability of EOP reports is unaffected by EFT and they typically are received by the end of the week following the checkwrite.

EDS must provide the following notification according to ACH guidelines:

> "Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date. The effective date for EFT under the Alabama Medicaid Program is Thursday following the checkwrite.
>
> However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATM) may not be aware of the deposit and the customer's withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution who, in turn, should work out the best way to serve their customer's needs.
>
> In all cases, credits received should be posted to the customer's account date and thus be made available to cover checks or debits that are present on the effective date."

Complete the attached Electronic Funds Transfer Authorization Agreement. **A voided check or official letter from the bank must be returned with the agreement to EDS.**

ELECTRONIC FUNDS TRANSFER AUTHORIZATION AGREEMENT

Note: Complete all sections below and **attach a voided check or official letter from the bank for verification purposes.**

Type of Authorization _____New _____Change

Provider Name	Group/Payee Provider No.
Payee Address	**Provider Phone No.**

Bank Name	ABA/Transit No.
Bank Phone No.	**Account No.**
Bank Address	**Type Account (check one)**

I (we) hereby authorize Alabama Medicaid Agency to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Alabama Medicaid Agency or its fiscal agent. I (we) understand that payment claims will be from federal and state funds, and that any falsification, or concealment of material fact, may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

_____ _____

Authorized Signature **(Original signature required)** Date

_____ _____

Title Internet Address (if applicable)

_____ _____

Contact Name Phone

Input By_____ Date _____

STATEMENT OF COMPLIANCE

Assurance is hereby given that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990, and the Regulations issued thereunder by the Department of Health and Human Services (45 CFR Parts 80, 84, and 90) no individual shall, on the ground of race, sex, color, creed, national origin, age, or handicap be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or services by this institution.

_____

Signature **(Original signature required)**

_____

Typed or Printed Provider's Name

_____

Date

Agency Copy *(Return with application)*

CR FORM-2

STATEMENT OF COMPLIANCE

Assurance is hereby given that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990, and the Regulations issued thereunder by the Department of Health and Human Services (45 CFR Parts 80, 84, and 90) no individual shall, on the ground of race, sex, color, creed, national origin, age, or handicap be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or services by this institution.

_____

Signature **(Original signature required)**

_____

Typed or Printed Provider's Name

_____

Date

Provider Copy *(Must be posted in facility)*

CR FORM-2

	Participation Requirements
Pharmacy	• **Operate under a permit or license to dispense drugs as issued by the Alabama State Board of Pharmacy or appropriate authority in the State where the service is rendered.** • **Agree to abide by the rules and regulations of third party billing procedures. Refer to Section 3.3.6, Third Party Liability, for more information.** • **Maintain records, including prescriptions, to fully disclose the extent of services rendered. Pharmacies should maintain records, such as purchase invoices and recipient signature logs, within the state of Alabama. At a minimum, prescription files and invoices must be available for examination.** • **Must submit copy of valid license for registered pharmacist.** **Out-of-State Pharmacies** • **Out-of-state bordering pharmacies, located within 30 miles of the border of the state of Alabama, may be enrolled as a regular Medicaid pharmacy provider. Out-of-state pharmacies not bordering Alabama, or located more than 30 miles from the state border, will be enrolled on a temporary basis for emergency situations.** • **Possess certification from the State Board of Pharmacy in the state where the pharmacy is registered and hold a permit to operate in the state of residence.** • **Complete an application for out-of-state pharmacies.** • **Agree to abide by the Alabama state provider tax law.** • **Alabama Medicaid program limitations apply to both out-of-state and in-state pharmacies. Medicaid uses the same payment methodology to reimburse out-of-state and in-state pharmacies enrolled with the Alabama Medicaid Program for drugs dispensed.** • **Must submit copy of valid license for registered pharmacist.**